The Linacre Quarterly

Volume 67 | Number 1 Article 8

February 2000

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Recommended Citation

Burke, Cormac (2000) "Psychiatry: A "Value-Free" Science?," *The Linacre Quarterly*: Vol. 67: No. 1, Article 8.
Available at: http://epublications.marquette.edu/lnq/vol67/iss1/8

Psychiatry: A "Value-Free" Science?

by

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The following is extracted from the "In Iure *Section" (i.e., the legal considerations) of a sentence of July 9, 1998, regarding the nullity of marriage, handed down by the Roman Rota. The rotal "Turnus" or panel of judges deciding the case was presided over by Msgr. Burke, who also wrote the decision.*

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2. This case hinges on whether, under c. 1095, 3 , a person with a homosexual tendency can validly consent to marriage. The main jurisprudential principles governing the question are well established and will be briefly recalled. In recent years, however, radical changes have marked many secular appreciations of homosexuality, perhaps especially within the field of psychiatry and psychology; and these changes certainly merit consideration, also so as to weigh their possible effect on canonical jurisprudence.

3. Homosexuality "is a disorder of the instinct, or that natural tendency (psychologically, physically and affectively) of one sex towards the other, which in the nature of things, that is through the Creator of nature, leads and urges people to that union of man and woman which is marriage" (c. Huot, Jan. 28, 1974: *R.R.Dec*., vol. 66, p. 28)[1]; homosexuality "is therefore considered a pathological state of the sexual instinct" (c. Pompedda, Oct. 6, 1969: vol. 61, p. 917).

"The incapacity for assuming certain substantial matrimonial obligations, as occurs in some graver cases of homosexuality, can certainly

not be harmonized with the nature of matrimonial consent" (c. Anné, Feb. 6, 1973: vol. 65, p. 64); "which principle has been followed without exception in later jurisprudence of our Apostolic Tribunal" (c. Funghini, Dec. 19, 1994: vol. 86, pp. 769-770). It follows that "not every expression of homosexuality can impede marriage. Homosexuality can only do so when one or other spouse suffers from true, i.e. grave and irreversible, homosexuality" (c. Pompedda, Oct. 19, 1992: vol. 84, p. 496).

Further, even if "according to doctrine and jurisprudence, homosexuality is a disordered instinct, that is, a serious affliction of the mind" (c. Pinto, Apr. 17, 1997. n. 4), jurisprudence distinguishes not only between grave and less grave cases of homosexuality, but also between a homosexual tendency that is transient and one that is deep-rooted, and again between an acquired homosexual condition and one that would seem to be constitutional: "among those who suffer a perversion or rather an inversion in the erotic appetite, one needs to distinguish those who give way to this aberration only transiently and on certain occasions, or impelled by circumstances of place or time, and who easily return to the right order when freed from these circumstances; these without doubt are in a totally different situation to others who either out of a habit firmly contracted over a long period (i.e. who have become homosexuals), or from their own constitutional makeup (who are therefore abnormal from birth), are irresistibly attracted to their own sex: which medical opinion considers to have originated in an organic cause or from a pathological psychic condition" (c. Pompedda, Oct. 6, 1969: vol. 61, p. 916).

4. In relation to the proof of an incapacitating homosexual condition, "as always occurs when the issue is incapacity for marriage, there must be proof of the gravity and the incurability of the [homosexual] disorder. For a slight inhibition or one that can be cured would give rise to an imperfect and perhaps also unhappy marriage, over a period or indefinitely. But the object of an incapacity is a null marriage, not one that is simply imperfect or difficult to live up to" (c. Serrano, July 28, 1981: vol. 73, p. 423).

Just as in other cases concerning possible consensual incapacity, in keeping with c. 1680 ("In cases of... defect of consent due to mental illness, the judge is to use the services of one or more experts"), jurisprudence has regularly considered recourse to medico-psychiatric experts as an important element within the probatory process of grave homosexuality. Truly qualified experts in the matter can help judges mature their decision in "such a difficult and complex matter" as homosexuality (c. De Lanversin: Jan. 26, 1996, n. 11). "Regarding proof: inasmuch as not every type of homosexual perversion but that alone which is grave and incurable, can invalidate consent, the judges must weigh the matter well in each

individual case, also seeking the opinion of experts – which it would be rash to ignore without serious reasons" (c. Parisella, May 11, 1978: vol. 70, p. 292). "It is obvious how necessary in these cases is the aid of experts, in order both to verify the existence of homosexuality and to diagnose its true nature and gravity" (c. Stankiewicz, Nov. 24, 1983: vol. 75, p. 683). "Regarding the proof of the existence of homosexuality such as to cause a person to contract marriage invalidly, apart from the facts and evidence produced, one needs to give accurate study to the expert opinions, which in practice as always needed to define the nature of this defect, and above all to distinguish its gravity" (c. De Lanversin: Jan. 26, 1996, n. 11). The premise here is evidently that psychiatric experts, with greater knowledge about the pathological nature of homosexuality, can provide the judge with a trustworthy and scientifically grounded opinion about the gravity of the homosexual condition in a particular case.

5. To what extent should these principles be modified in the light of the radically changed position of so much the secular world with regard to homosexuality?

Until twenty or thirty years ago, homosexual conduct, even between consenting adults, was treated as a criminal offense in civil law, and was socially considered an unacceptable deviation. This was reflected in psychiatry, where it was universally held to be a psychic illness needing therapeutic attention. In 1973 however, the American Psychiatric Association (or rather its Board; see below, no. 30), despite no small number of dissenting voices from within the psychiatric profession itself, eliminated homosexuality from the listed classification of a mental disorder, then in 1980 restricted any diagnosis of pathology to cases where homosexuality caused subjective distress ("ego-dystonic" homosexuality), limited this further in 1987, and finally in 1994 removed homosexuality completely from any categorization as a personality disorder.

6. Currently it is often asserted, and perhaps popularly believed, that the traditional evaluation of homosexuality as an anomalous condition has been proved wrong by *scientific* advance. One reads for instance: "As a result of scientific discussion, the American Psychiatric Association in 1973 eliminated homosexuality from its list of mental illnesses and, in 1980, dropped it from its *Diagnostic and Statistical Manual of Mental Disorders*" (*Encarta Multimedia Encyclopedia*, CD-ROM 1998 edition: under "Homosexuality"). Ecclesiastical jurisprudence cannot remain indifferent to these great changes, being bound rather to examine what theoretical or practical effect they may have on the canonical appreciation of homosexuality, in particular with regard to capacity for valid marital

consent.

7. The case before the court today invites us also to look briefly at the thesis that homosexuality can be classified as a personality disorder only when it is "dystonic", not when it is "syntonic". This thesis, expressed in these unusual terms of differentiation, was introduced into DSM-III (1980), maintained even if with a certain veiling in DSM-III-R (1987), and then dropped completely in DSM-IV (1994) when all mention of homosexuality disappeared from this handbook of the American Psychiatric Association. The distinction however is still invoked by no few psychiatrists. In the case before us the affirmative decision of the appeal court, as well as the petitioner's rotal advocate, highlight the court expert's opinion in second instance that the respondent suffered from "egodystonic lesbianism", or "egodystonic homosexuality".

8. The changes noted above, regarding the psychiatric classification of homosexuality, generate considerable puzzlement. They raise questions concerning many current evaluations of homosexuality, and provoke doubts especially as to whether these can be harmonized with the Christian vision of sexuality and of its place in the healthy and integral development of man. More in particular, they necessarily inspire serious concerns about the scientific reliability of certain new and extremely influential theses that have risen in a very brief period to an authoritative position in contemporary psychiatry and psychology.

9. While these particular changes are not exclusive to the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM"), they are specially noticeable in this Manual, each new edition of which has been marked by numberless additions, omissions and reformulations covering many other fields besides homosexuality. No doubt in most cases these represent conclusions of research work that has been guided by exclusively scientific criteria. However many prominent psychiatrists maintain that this has not always been the case. Some in fact maintain that psychiatrists cannot be said to operate with an absolutely "neutral" scientific mind, for value judgments always underpin their work.

The importance of this for jurisprudential purposes is all the more evident when one recalls that in cases concerning possible consensual incapacity for marriage (and in keeping with c. 1680), canonical tribunals have come to rely heavily on experts in psychiatry and psychology, while these experts themselves tend to invoke DSM more and more. Judges tend to have a copy of DSM to hand and very frequently ask periti to give their diagnoses using DSM classifications, in the conviction that this provides

the judge with a means to calibrate the scientific reliability of an expert opinion.

10. DSM is not only utilized by the American psychiatric profession, but has now become a manual of international use, having been translated into all the leading languages. Special note must be made of the enormous authority which it has come to enjoy in church tribunals and among ecclesiastical court experts. In rotal jurisprudence itself, DSM is described in a way that reflects the frequency of its use: it is called the "renowned work" (vol. 81, p. 311; vol. 84, p. 266); "It is therefore worth referring to this work which is today easily the leading account of mental disorders" (vol. 85, p. 625), "the greatly used text" (vol. 84, p. 648), "the constantly used list of mental disorders" (vol. 85, p. 624), "the well known DSM Manual" (vol. 87, p. 151), and its terminology as the "commonly recognized listing" (vol. 83, p. 766). In rotal sentences of the period 1990-1995 which treat of consensual incapacity, DSM is referred to some 200 times.

11. Two main questions about this Diagnostic Manual call for consideration: a) its reliability from the strictly scientific viewpoint, as a trustworthy source of unbiased knowledge; b) its harmony or otherwise, at least in areas such as the one that concerns us today, with the Christian concept of man. Both questions are of major concern to ecclesiastical judges and advocates, as well as to court experts working in the service of church tribunals.

12. In approaching the first question, it is helpful to take note of the genesis and development of DSM itself. The first edition of the *Diagnostic and Statistical Manual of Mental Disorders*, which listed some 60 mental disorders, was in 1952. Dr. Morton Kramer and Dr. Robert L. Spitzer were main consultants in its production and also in that of the second edition (1968), revised under the aegis of the American Psychiatric Association. The terms settled on by *DSM-II* became "the official nomenclature for American psychiatrists on July 1, 1968" (DSM-II, p. 120). The work was greatly revised and expanded in its third edition, *DSM-III*, published in 1980. Dr. Robert L. Spitzer was again the main consultant for this work. *DSM-III-R* appeared in 1987. Another major revision resulted in *DSM-IV*, which was published in 1994 and lists more than 300 mental disorders.

13. *Opinions among psychiatrists about the scientific reliability of DSM.* There is very considerable professional disagreement between psychiatrists themselves about whether the development of DSM has

always been shaped by purely scientific judgments, and therefore whether many of the diagnostical parameters it proposes can claim to be of a properly scientific and validated nature. Tribunal personnel clearly need to be aware both of the existence and the extent of these differences of opinion.

Dr. Melvin Sabshin, a noted U.S. psychiatrist, delivered the Adolf Meyer lecture – "Turning Points in Twentieth-Century American Psychiatry" – to the 1989 meeting of the American Psychiatric Association (*American Journal of Psychiatry*, vol. 147 [1990], pp. 1267-1274). Dr. Sabshin notes how DSM came into being in the 1950-1960s to counter the widespread public feeling that psychiatry both lacked a sufficiently scientific base and was subject to manipulation by other interests in society. "Publicity about psychiatrists testifying on opposite sides of insanity defense pleas brought out enormous criticism about the unreliability of psychiatric diagnosis" (p. 1272). DSM was an attempt to prove that psychiatric disorders could be objectively diagnosed. Evidently, a first condition to establish and safeguard the scientific repute of the Manual is that it should be seen to have shielded itself from non-scientific pressures. In this respect while Dr. Sabshin has no doubt that "DSM-III and DSM-III-R have influenced American psychiatry profoundly", he goes on "but they have also been influenced *by forces outside the field*" (ib. 1271); repeating on the following page that they have not always been successful in resisting pressure from non-scientific political and social activists (ib. 1272).

14. The doubts expressed by Dr. Sabshin had already been aired within the psychiatric profession, after the publication of DSM-III in 1980. The *American Journal of Psychiatry* in 1984 carried an important "Debate on DSM-III" with Dr. Robert L. Spitzer, Professor of Psychiatry at Columbia University, New York, and the main mind behind DSM-III, responding to criticisms from other prominent psychiatrists (*American Journal of Psychiatry*, vol. 141, pp. 539-553; cf. also the judgment *coram* the undersigned of November 25, 1993: vol. 85, pp. 706-707). The debate shows that even supporters of DSM-III admit the unscientific character of many of the changes it introduces, and urge that future developments should be more solidly based. Dr. Gerald L. Klerman, Professor of Psychiatry at Harvard Medical School, requests that "the changes that [will] appear in DSM-IV should be determined *by the state of evidence* rather than *the assertions of competing ideological camps*" ("The Advantages of DSM-III": p. 540), while Dr. George E. Vaillant, Professor of Psychiatry at Dartmouth Medical School, holds: "DSM-III represents a

bold series of choices based on guess, taste, prejudice, and hope. Some of these choices are undoubtedly right, *but few are based on fact or truth*... Certainly I hope that the authors of DSM-IV will rectify the mistakes of DSM-III" ("The Disadvantages of DSM-III outweigh its Advantages": ibid. p. 545 [emphasis added]).

Dr. Vaillant goes on to detail his criticisms. The first is that "DSM-III is parochial: [it] ignores other cultures and other historical epochs and ignores any aspect of learning that does not come under the heading of American practical technology" (ibid. 542). Dr. Robert L. Spitzer in effect accepts this criticism: "First, [Dr. Vaillant] states that DSM-III is "parochial" because we ignored other cultures. That may be the case, but the mandate was to develop a classification of mental disorders for use in this country. We certainly were not told to worry about the complex problems involved in developing a system that could be used throughout the world" (ibid. 546). It is not certain that this important clarification has been adequately noted in translations of DSM and in the use made of it (and of works based on it) in different countries. The *Introduction* to the latest edition of DSM points out: "Applying Personality Disorder criteria across cultural settings may be especially difficult because of the wide cultural variation in concepts of self, styles of communication, and coping mechanisms" (DSM-IV, xxiv).

15. Dr. Vaillant applies his censure of the "parochial" nature characterizing many diagnostical criteria proposed by DSM-III particularly to "antisocial", "borderline" and "narcissistic" personality disorders. He relates how DSM's description of "antisocial disorder" seemed "utterly preposterous" to experienced European psychiatrists. He goes on: "How much more vulnerable than antisocial personality are the classifications of borderline and narcissistic personality disorders! Only 10-20 years old, these disorders are still usually observed only in American cities that have opera houses and psychoanalytic institutes. Borderline and narcissistic personalities are rarely seen in Iowa City or in Mobile; certainly, they are not recognized in Tangiers or Bucharest" (ib. 543). While a sentence coram Colagiovanni notes the novelty of the narcissistic classification: "from 1980 the classification «Narcissistic Personality Disorder» (cf. DSM-III) was introduced" (May 17, 1994, no. 17; unpublished), references to narcissistic disorder appear at least 85 times in cases brought to and judged by the Rota between 1990 and 1996.

16. Another psychiatrist recalls "embarrassments" that the psychiatric profession has had to undergo due to evidence of diagnostic unreliability,

and cites the "Rosenhan study". "In that study 19 normal subjects presented themselves to psychiatric hospitals complaining of a putative symptom; each said that he or she heard a voice saying "thud". All were hospitalized, and all acted "normally" while hospitalized. And all were discharged with the diagnosis of "schizophrenia in remission". This study was reported in the journal *Science* under the ominous title "Being Sane in Insane Places". Rosenhan interpreted his results to assail the unreliability of psychiatric assessment and the dangerousness of misdiagnosis (Dr. Mitchell Wilson, "DSM-III and the Transformation of American Psychiatry": *American Journal of Psychiatry*, vol. 150 (1993), 404).

17. The self-doubts about the reliability of DSM continue to be voiced at the highest level within the psychiatric profession. In a very recent editorial of the *American Journal of Psychiatry*, we read: "the new DSM diagnostic process has dominated the research, teaching, and contemporary practice of psychiatry. The DSM diagnosis has almost become a thing in itself – a certainty of 'concrete' dimensions. The DSM diagnosis has become the main goal of clinical practice. DSM-IV, as 'allegedly' being more data based, has even assumed the aura of allowing psychiatry to keep pace with the rest of medicine as a 'technological triumph'; but our current diagnostic process and zeal may also be ruining the essence of psychiatry. It is time to look at what we have wrought and make some midcourse corrections... The current DSM process gives *the image* of precision and exactnesss. In fact, many have come to believe that we are dealing with clear and discrete disorders rather than arbitrary symptom clusters... All of *this apparent precision* overlooks the fact that as yet, we have no identified etiological agents for psychiatric disorders. *Our diagnoses are nowhere near the precision of the diagnostic processes in the rest of medicine*" ("Putting DSM-IV in Perspective": *American Journal of Psychiatry* vol. 155 [1998], p. 159; emphasis added).

18. In justice to the editors of DSM, it must be said that from the outset they have clearly stated the limited purpose of their Manual: "The purpose of DSM is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders" (DSM-III-R, xxix; DSM-IV, xxvii). DSM-IV repeats the "Cautionary Statement" of DSM-III-R; but expands it with a specific caveat about the "Use of DSM-IV in Forensic Settings": "When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern

to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder', 'mental disability', 'mental disease', or 'mental defect'. In determining whether an individual meets a specified legal standard (e.g. for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis" (DSM-IV, p. xxiii).

A rotal peritus in a 1992 case would seem to have had this in mind when he observed: "DSM-III-R has been and is still subject to strong criticism because of the criteria according to which it has been formulated", and "as the Preface itself to the Manuals states, the diagnostic criteria used may not be relevant for medico-legal purposes". The expert adds: "It must not be forgotten that DSM-III-R originated as a Manual to be used for epidemiological purposes (that is, for the classification of diseases), and was only subsequently used as an actual 'Manual of Psychiatry'" (c. Ragni, May 19, 1992: vol. 84, p. 266).

19. Nevertheless, DSM continues to exercise a growing influence which goes very much beyond its original intention of simply providing a common nomenclature. The mode in which it is invoked in the very title of certain works seems to illustrate this. For instance, AA. VV., *Diagnosi psichiatrica e DSM-III-R. Aspetti clinici e prospettive medico-legali*, Milan 1989; Gabbard G. O., *Psichiatria psicodinamica. Nuova edizione basata sul DSM-IV*, tr. it., Milan 1995.

No small number of cases coming to the Rota suggest that, for some judges and experts, the slightest evidence that some of the diagnostic criteria proposed by DSM for identifying a psychic disorder were present at the time of consent, suffices to *prove* a party's incapacity for marriage under c. 1095. Such a practice not only pays no attention to the "Cautions" given by DSM itself, but ignores two other evident facts: a) DSM, in its explicit desire to be exhaustive, classifies many "disorders" which cannot be even remotely connected with capacity for the *essential obligations of marriage* (as c. 1095 requires); b) no less importantly, it passes over the clear principle, long established in rotal jurisprudence and recalled in 1987 by Pope John Paul II, that "an argument for real incapacity can be entertained only in the presence of a *serious* form of anomaly..." (AAS 79 (1987) 1457). The editors of DSM-IV seem to have wished to preclude such superficial reading or use of their Manual when they write in their Introduction: "It is precisely because impairments, abilities, and disabilities *vary widely within* each diagnostic category that assignment of a particular diagnosis *does not imply a specific level of impairment* or disability"

(DSM-IV, p. xxiii).

The editors add another "caveat" which is specially significant for those who habitually have recourse to DSM for canonical cases under c. 1095. "The fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's *degree of control* over the behaviors that may be associated with the disorder. Even when *diminished control* over one's behavior is a feature of the disorder, having the diagnosis in itself *does not demonstrate* that a particular individual *is (or was) unable to control* his or her behavior at a particular time" (ibid.). This distinction in DSM between "diminished control" and "inability to control", corresponds to the distinction in canonical jurisprudence between "difficulty" – which does not invalidate consent – and "incapacity", which does. This is firmly established in rotal jurisprudence (c. Ewers, April 4, 1981: vol. 73, p. 221; c. Pompedda, Feb. 19, 1982: vol. 74, p. 89, c. Agustoni, July 15, 1986: vol. 78, p. 460; c. Bruno, Dec. 18, 1987: vol. 79, p. 765; c. De Lanversin, Jan. 19, 1994: vol. 86, p. 5, n. 11; c. Civili, June 15, 1994 (unpublished); c. Colagiovanni, July 28, 1994; (unpublished); c. López-Illana, Dec. 14, 1994: vol. 86, p. 691, etc.), and was also recalled by the Pope in his address to the Rota in 1987: "For the canonist the principle is clear that *incapacity* alone, and not just *difficulty*, in giving consent and achieving a true community of life and love, renders marriage null" (AAS 79 [1987] 1457).

20. *Psychiatry and science.* Almost fifty years ago an authoritative article observed: "In mental health, the contribution of organic, psychological, and social and ideological factors defies specification. There are no methods through which the factors can be observed in isolation so that their relative causal significance might be estimated; often the factors themselves cannot be identified easily through specific criteria that would lead themselves to measurement, comparison, and correlation" (Dr. Joseph W. Eaton: "The Assessment of Mental Health", *American Journal of Psychiatry*, vol. 108 [1951], pp. 81-90).

In a much more recent article, "Psychiatry is More than a Science" (*British Journal of Psychiatry*, vol. 162 [1993] 154-160), Dr. R.H. Cawley, Emeritus Professor of Psychological Medicine in the University of London, holds that psychiatry, related so much to individuals and dependent on many non-analyzable elements, cannot be enclosed in the category of a strict science. Having noted that "the raw material of the psychiatrist's work consists of the behaviour, thoughts and emotions, objectively expressed and subjectively experienced, of persons in distress and those in close contact with them", he goes on to suggest that "there are six crucial aspects of our discipline which are in principle unrelated to the basic

sciences and yet are central to what we are doing"; these are "the uniqueness of the individual, his/her awareness of self, inner feelings, empathy, and interaction and alliances with others", which, he claims, "are primary experiences, and will never be subsumed under the rules of science" (154-157).

21. Psychiatry, in its actual practice, uses certain therapies which can properly be regarded as scientifically based. This is evident in the pharmacological treatment of psychic disorders which has developed so notably over recent decades. These developments certainly represent scientific progress for psychiatry and allied specialties, even though pharmaceutical researchers, and still more psychiatrists, are often unable to provide any sure explanation of the cause-effect factors involved.

Other aspects of therapy, such as psychiatric and psychological counselling, often show a great level of skill. Always supposing that this counselling is competently done, it seems that here one should speak of the increased mastery of an art, rather than of scientific progress. Many use this art well, some use it badly; a judgment which depends also on one's anthropological presuppositions.

22. The original and stated goal of DSM – conceived as an aid to diagnosis – was (and remains) eminently utilitarian: to elaborate common diagnostical terms and criteria for use by practitioners, and thus to reduce the difficulties of dialogue and communication which have so beset the profession. Hence the purpose was to obtain a practical or political arrangement, rather than any real increase in objective knowledge. Whatever advances may have been made here are therefore technical more than strictly scientific. One would say the same of a new system of classification introduced into a university library.

As we have noted, however, leading psychiatrists consider that the original limited and pragmatic purpose of DSM has been extended and substantially modified over the past twenty-five years. On the one hand, DSM has gradually come to list as psychic "disorders" (each with its appropriate symptoms) many character flaws or defective ways of being which were previously not considered a matter for psychiatric treatment at all. On the other, it has removed from the classification of disorder certain conditions which were formerly and universally accepted as gravely anomalous. Moreover (as we have seen in part and will now further illustrate), quite a number of prominent psychiatrists consider that many of these changes have been culturally conditioned, rather than scientifically developed. Precisely because of the extraordinary popularity which DSM has achieved over a short period of time, it should be borne in mind that

popularity is per se no validation of intrinsic scientific authority.

23. *Cultural influences on psychiatry.* Few psychiatrists would deny that concepts of "psychic health" are enormously influenced by current standards of acceptable personal or social behavior. Hence the danger that both psychiatry and psychology can be unduly subordinated to, or manipulated by, prevailing cultural or class values. This danger has often been noted in the past, and it is certainly not less operative today. We quote again from the article by Dr. J. Eaton: "Cultural relativity plays a much larger role in the fields of mental health and illness than in most other fields of medicine. An inflamed appendix has a fairly uniform meaning in all cultures that recognize life as a desirable value. If left untreated it is a threat to life. Not so in the mental field. Even in the case of very unusual behaviors, like suicide, one cannot find complete cross-cultural uniformity in its interpretation... in the United States the mental hygiene movement has accepted the democratic, worldly, ascetic, individualistic, utilitarian, and competitive values of the middle class. *Its criteria for mental health reflect strong personal and class biases and are in part rejected by other sections of the population.* Karen Horney emphasizes that, even within our culture, concepts of mental health and illness vary considerably through time: "... If a mature and independent woman were to consider herself a 'fallen woman', 'unworthy of the love of a decent man', because she had sexual relationships, she would be suspected of neurosis, at least in many circles of society. Some forty years ago, this attitude of guilt would have been considered normal..." (loc. cit., p. 86).

"*Experts do not agree on the meaning of mental health.* Psychiatrists and clinical psychologists have *personal criteria* of the requirements to consider a patient 'cured' [or 'healthy']. These criteria arise out of their experience and *social value orientation.* No common denominator for these definitions can be found" (ib. 82). "A frank recognition of the relativity of mental health will do much to improve both research and its application. It will reduce confusion by putting an end to the fruitless effort to arrive at a single criterion, which some scientists hope would be endowed through some magical process with the 'objectivity' of temperature measured by a thermometer. Mental health cannot be reduced to such a single dimension. *It is a value judgment*, with all the potentialities for variation and change implicit in such a relativistic entity" (ib. 89).

24. No association of physicians would seriously consider and debate (and much less incorporate into their diagnostical practice) the "scientific"

conclusion of a study which holds cancer to be a healthy and not a pathological state; and no doubt the same is true, at least for the moment, regarding the effects of drug-taking on the human organism. Yet what is probably the major official body claiming to speak for psychiatry today has, under outside pressure, done exactly this in the matter of homosexuality. In other areas, psychiatrists testify to how modern secular life-style values shape diagnoses concerning self-identification and self-fulfillment, maturity of personality, privacy, gender roles, race, social status, religious belief, etc.

25. *Psychiatry and human values.* In dealing with the troubled workings of the human spirit, psychiatry inevitably (even if perhaps unconsciously in some cases) adopts a series of philosophically or morally based *value judgments*: about "concepts of self" (DSM-IV, xxiv; cf. above no. 14), about man himself, his nature, his development and end, his psychic good and health. Tribunals could take special note of a strikingly clear admission – and indeed assertion – of this, also because of the level of the professional forum at which it was made. Dr. Alan A. Stone, Professor of Law and Psychiatry at Harvard University and 1980 President of the American Psychiatric Association, in his Presidential Address to the Association – "Conceptual Ambiguity and Morality in Modern Psychiatry" – clearly rejected any pretension that psychiatry is a purely scientific endeavor, free from any underlying values or moral presuppositions. Several passages merit quoting from this significant address (*American Journal of Psychiatry*, vol. 137 [1980]; pp. 887-891).

Dr. Stone firmly holds that, despite theoretical assertions that psychiatry is "value-free", this is not so in practice. "Psychiatry does not stand outside history or morality, but how do we decide which history and which morality to accept? ... Psychiatrists are taught to avoid value judgments in their dealings with patients, but I do not believe I make a radical claim when I assert that history and morality are a presence in the therapist's office. The only question is how do they get there. The theory that excludes history and morality has the power to exculpate without disturbing the status quo. Thus the psychiatrist's choice of theory becomes crucial" (888).

With concrete reference to "racism, homosexuality and the situation of women", Dr. Stone insists that "these are all issues which have confronted us in our practice, challenged *the moral assumptions that lie concealed in our theories*, and confounded us with disputes and acrimony in our Association", also because "each invites psychiatry to take a stand on human values" (887). He goes on to note: "Psychiatry has played no small part in the transformation of the mind of modern man"... "*The most*

powerful aspect of psychiatry is its contribution to what it means to be a person. This is not under our control, nor can it be in a free society. But we do bear a certain responsibility, and one of the themes in that responsibility is the *hidden values* in the theories and therapies that *originated with us* and contribute to the shaping of contemporary consciousness... We have been engaged in an enterprise that *involves concealed positions on human values*, moral postures, and even politics. This claim comes not just from unfriendly critics, it comes from responsible colleagues. This is the indictment that confronts those psychiatrists who assert that their psychiatry has nothing to do with these things; although the indictment can be overdrawn and viciously expressed, the fundamental truth in it cannot be gainsaid. Therefore, given the power of our enterprise, whether we like it or not we are in some measure responsible for the influence of these hidden values. It is also important to remember that *many of us have wanted to use psychiatry to influence the public* to confront and even to treat the sick society through the media. It is not just a matter of aloof scientists being victimized by the vulgarity of the mass media" (890).

A scarcely less eminent authority, Professor R.H. Cawley of the University of London, in an article that we cited earlier, asserted frankly that psychiatry "is grounded in the humanities as well as [in] science", and therefore ultimately rooted in a certain philosophical outlook. Hence "much is to be gained by *systematic exploration of the philosophical dimensions of psychiatry*". A major conclusion he comes to is: "Among the humanities, the one subject that may prove to have relevance to appropriate [psychiatric] theory and competent practice is philosophy. There is reason to believe that studies in philosophy in relation to psychiatry may in due course strengthen the conceptual basis of the subject and enable *the non-science aspects of psychiatry* to become orientated in the world of knowledge and thought" ("Psychiatry is More than a Science": *British Journal of Psychiatry*, vol. 162 [1993], 157-158; 160).

26. It is significant to find these opinions, from such authoritative voices within the psychiatric profession, insisting that theirs is not an exact science, but one which relies heavily on «value judgments», on philosophy and anthropology, and also on theses rooted in sociological premises. A recent article in the *British Journal of Psychiatry* (which holds that psychiatry "is a social practice") stresses "the new approach to psychiatric knowledge which has developed under the influence of social anthropology over the last decade", and asserts that psychiatry "is too socially embedded in the sense that it cannot examine its own institutional assumptions, and mistakes the particular for the universal" (R. Littlewood: "Against

Pathology. The New Psychiatry and Its Critics": *British Journal of Psychiatry*, vol. 159 [1991] pp. 696, 699).

27. In this context and in reference to DSM, a secular source notes: "Critics of DSM believe that the book regards too many normal human traits and behaviors as possible psychiatric illnesses. They are concerned that DSM authors sometimes use personal and social values, rather than scientific evidence, to judge whether behavior is abnormal" (*Encarta Encyclopedia*, loc cit. supra, no. 6).

28. Reflecting on all of the above, the canonist's mind is naturally drawn to the 1987 Address of Pope John Paul II to the Roman Rota. There the Pope insisted on the ecclesiastical judge's responsibility, in marriage nullity cases, to detect and evaluate the anthropological or philosophical presuppositions that necessarily underlie a psychiatric or psychological opinion. The main points of the Address were noted by G. Versaldi in an article published shortly after ("Momentum et consectaria allocutionis Joannis Pauli II d. 5 februarii 1987" *Periodica* 77 [1988], pp. 109-148). Recalling the Popes words, "dialogue and a constructive communication between the judge and the psychiatrist or psychologist are easier if the frame of reference for both is a common anthropology, so that, even allowing for differences of method, interests and objectives, the approach of one is open to that of the other", Versaldi comments:

> John Paul II warns that before a Judge compares the Expert's conclusions with the other elements of the case, *he should carefully examine those anthropological presuppositions* on which the expertise is based and *which can have a determining effect on its technical conclusions*. Here the Pope is without any doubt *indicating the impossibility of the psychological sciences being neutral*, since they cannot in fact have a purely technical function, but need to look to the metaphysical-normative sciences for those first principles whose absence confines human nature within the limits of immanent phenomena, without any possibility of transcendence towards God. This necessary relationship with the metaphysical sciences in no way impairs the autonomy of the psychological science, which conserve their peculiar method and purpose, along with the limits of their competence, because "they cannot offer a their own truly integral concept of the human person" (no. 2). This view doubtlessly goes against the concept dominant in modern psychological schools of thought which hold that psychology should not only be autonomous, but even independent or neutral regarding any anthropological first principles. But, *since such neutrality is impossible in practice*,

these same schools construct anthropology, which is based on deterministic and immanentist ideas.

In view of this, one sees clearly the need for a critical pondering by the judge of the anthropological principles in question. Without this pondering one can easily go astray, since the conclusions of the expert can be tarnished with these false elements. Hence a simple uncritical analysis of the conclusions is not enough, for, as the Pope says, "the dialogue, having started on the basis of this initial ambiguity, can easily lead to conclusions which are false and harmful for the real good of individuals and of the Church" (no. 3). Here we touch on another important aspect of the Holy Father's address, which seems to have escaped the notice of many. He not only criticizes the unwarranted multiplication of declarations of nullity on grounds of psychic weakness, but also indicates the main cause of this, in the way that the judge is often lead astray by psychological expertises. This erroneous appreciation *does not relate directly to the expert's conclusions, but refers above all to the anthropological presuppositions which, however much the experts may deny it, are inevitably involved in the psychological analysis of persons* (114-115).

9. *Is homosexuality a psychiatric disorder?* What we have seen so far can help as we turn our attention more specifically to the evaluation of homosexuality in the secular psychiatric world. In the first editions of DSM, homosexuality was unambiguously classified as a mental disorder. In DSM-II, published in 1968, homosexuality is repeatedly listed under the heading of "Sexual deviations" (pp. 10, 44, 79, 127). It appears first among these deviations, with the "Code number" 302.0, being followed by Fetishism (302.1), Pedophilia (302.2), Transvestism (302.3), etc. (p. 44). Regarding all these deviations, the general observation is made: "Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them" (ibid.).

In 1973, as noted above, the decision was taken by the governing body of the American Psychiatric Association to eliminate homosexuality from the category of a psychic disorder. DSM-III, published in 1980, while listing a whole series of "Psychosexual Disorders", including Transvestism (269) or Pedophilia (271), says that "homosexuality itself is not considered a mental disorder" and, more specifically, "Homosexuality that is ego-syntonic is not classified as a mental disorder" (282). "Ego-dystonic homosexuality" is however categorized as a psychosexual disorder (261; 281-282). This is explained on p. 359: "a homosexual arousal pattern that is unacceptable to the individual would be ego-dystonic, whereas, if the

individual were not distressed by the pattern and experienced it as acceptable, it would be ego-syntonic" (DSM-III, p. 359).

When we go on to DSM-III-R (1987), we find that in the main text, homosexuality is not referred to at all. The only mention is in the end Index under "Ego-dystonic homosexuality" (Index: p. 560, p. 561), where the reader is referred to p. 296 of the text. However, the term "homosexuality" does not appear on p. 296, which deals very briefly with "Sexual disorder not otherwise specified". One is left to infer that the reference is to the third illustration given of this unspecified type of sexual disorder: "persistent and marked distress about one's sexual orientation".

In DSM-IV (1994) homosexuality is nowhere mentioned. In the Introduction to DSM-IV, one is struck by the open admission by the main editors that the many specialists who took part in its elaboration were selected for their readiness to participate in a highly organized "consensus" project that would, it seems, prescind *a priori* from certain "previously held views" [which are not specified]. "DSM-IV was the product of 13 Work Groups... We took a number of precautions to ensure that the Work Group recommendations would reflect the breadth of available evidence and opinion and not just the views of the specific members... We selected Work Group members who represented a wide range of perspectives and experiences. Work Group members were instructed that they were to participate as consensus scholars and not as advocates of previously held views. Furthermore, we established a formal evidence-based process for the Work Groups to follow" (xv).

30. The 1993 article by Dr. Mitchell Wilson, quoted above, refers particularly to the homosexual issue as provoking the first of "public embarrassments of the profession which bore directly on the problem of diagnostic reliability [and] contributed to the near-crisis in the legitimacy of psychiatry in the early 1970s – the controversy over the disease status of homosexuality. Increasingly vocal gay rights organizations lobbied to have homosexuality removed from DSM-II. In 1973 the American Psychiatric Association Board of Trustees, after evaluation by the relevant hierarchy of APA components, voted to strike homosexuality from DSM. It was less clear that this was a scientific issue than that it was, at least in part, a political one. The homosexuality controversy seemed to show that psychiatric diagnoses were clearly wrapped up in social constructions of deviance" (*American Journal of Psychiatry*, vol. 150 [1993], 404).

An editorial in the leading British psychiatric journal also cites the homosexuality issue as an example of how factors other than those which are properly *scientific* influence the shifting standards and parameters of modern psychiatry: "the boundaries of psychiatric conditions are constantly

shifting, much more often in response to socio-political pressures than to the accumulation of scientific evidence. A striking example is the majority vote of the American Psychiatric Association to exclude homosexuality from DSM-III" (Julian Leff: "The New Cross-Cultural Psychiatry", in *British Journal of Psychiatry*, vol. 156 [1990], p. 305).

The address referred to above of Dr. Alan A. Stone, Professor of Law and Psychiatry at Harvard University and 1980 President of the American Psychiatric Association, should be specially noted in this context. He considers homosexuality to be one of the most important instances where the moral appreciation underlying the common professional psychiatric assessment of a concrete pathological condition yielded to a campaign mounted by lobby interests, and adopted a new official approach which itself corresponds to a very different set of underlying "hidden values".

> One of the first great battlefields in the attack on psychiatry's hidden values was homosexuality. Psychiatrists had long assumed that as part of their humanistic tradition they had brought their scientific perspective to things that were once considered evil. Homosexuality became sickness rather than sin, and this perspective in this century was accepted not only by the secular masses but even by most religious authorities. However, gay liberation brought a different perspective. Their argument was that our judgments about homosexuality as sickness contained hidden values, a limited vision of human sensuality and intimacy, the old morality under a new guise, and perhaps even our own phobic limitations. A campaign was undertaken to remove the diagnosis of homosexuality from the nomenclature. Our Association, after considerable deliberation and not a little acrimony, accepted that perspective. Our Association went even further – it called for an end to legal discrimination against homosexuality (*American Journal of Psychiatry*, vol 137 [1980], 890).

After this analysis of how the American Psychiatric Association responded to "the effort to influence the public perception of homosexuality", Dr. Stone concludes: "My analysis in no way is meant to demean the decisions our Association reached. Nor do I minimize the importance of what we did. It was not an empty gesture. But I believe the real significance of our actions once again was moral. We changed the moral element in our composite sketch of homosexuality" (ib. 891). Therefore, according to this prominent scholar and psychiatrist, the new and radically changed "official" approach to homosexuality can in no way

be considered a truly scientific advance, since it was simply the political option of some within the profession, against the strenuous resistance of others, to accommodate a new value judgment regarding the social acceptability of a homosexual condition.

31. It is not surprising then to see that canonical periti, who are so accustomed to refer to DSM when giving opinions about other anomalous conditions, now find such reference very difficult when the anomaly is homosexuality. This difficulty can already be partly detected in a rotal sentence of November 24, 1983 (vol. 75, pp. 676ss). A more recent sentence of December 19, 1994 (vol. 86, p. 781), in accepting the expert opinion as basis for its conclusion that the respondent "had a tendency towards his own sex as an impulse he could not resist" and that in consequence the marriage was null (783), sums up this opinion so:

> The Expert considers it certain : a) "that the psychosexual behavior of Mr. Peter is not within the norm. He considers that it falls within the sphere of the DSM-III disorder, no. 302.89"; b) "We are not in the presence of a 'permanent deviation of the personality of a homosexual type'", but the respondent is under a "non-typical personality disorder according to the international DSM-III classification... a non-classified behavioral disorder, i.e. a disorder of identity and sexual behavior with features of a homosexual nature"... (781).

It could be considered peculiar that the peritus (in 1994!) chooses to refer back to DSM-III, published in 1980. Even then, he still has obvious difficulty in formulating his opinion according to the Manual. He makes no reference to the later editions.

32. *Homosexuality in Christian anthropology*. On the one hand, then, it is clear that over the past twenty-five years the psychiatric profession, through the main official body representing it and in its main sponsored work, has completely changed the evaluation of homosexuality proposed from the viewpoint of psychic health. On the other hand, many prominent psychiatrists are not content with this "de-pathologizing" of homosexuality and openly assert that it is a response to ideological preference, not to scientific discovery.

In any case, even if the majority of psychiatrists – for whatever reasons – were to conclude that homosexuality is no longer to be considered a disorder, Christian anthropology cannot accept this conclusion. According to the Christian understanding of man, human nature, weakened though not intrinsically corrupted by Original Sin, is

beset in almost all of its faculties and powers by disordered tendencies, whose presence there calls for a constant struggle (Denz. 1515). Every normal person experiences these disturbed tendencies in a particularly strong way in the whole area of sexuality. Hence the concept of "normality", in regard even to *hetero*sexuality, is somewhat equivocal, for the "normal" heterosexual person also experiences disorders and must continuously strive to correct or check these deviations, so as to keep his or her balance in what is a basically turbulent situation.

The *Catechism of the Catholic Church*, treating of sexuality in general, insists that it needs proper integration into the existence of each person – a vital task that cannot be achieved without the exercise of the virtue of chastity and the use of human and supernatural means. "All the baptized are called to chastity [which] means the successful integration of sexuality within the person"; "Chastity includes an apprenticeship in self-mastery which is a training in human freedom. The alternative is clear: either man governs his passions and finds peace, or he lets himself be dominated by them and becomes unhappy"; "Self-mastery is a long and exacting work. One can never consider it acquired once and for all. It presupposes renewed effort at all stages of life" (nos. 2348, 2337, 2339, 2342).

33. On this background, the Catechism goes on to speak of homosexuality. "Homosexuality refers to relations between men or between women who experience and exclusive or predominant sexual attraction toward persons of the same sex... Tradition has always declared that homosexual acts are intrinsically disordered. They are contrary to the natural law... Under no circumstances can they be approved". "The number of men and women who have deep-seated homosexual tendencies is not negligible. They do not choose their homosexual condition; for most of them it is a trial... These persons are called to fulfil God's will in their lives and, if they are Christians, to unite to the sacrifice of the Lord's Cross the difficulties they may encounter from their condition". "Homosexual persons are called to chastity. By the virtues of self-mastery that teach them inner freedom, ... by prayer and sacramental grace, they can and should gradually and resolutely approach Christian perfection" (nos. 2357-2359).

The Church therefore holds that homosexuality is a disorder, whether considered as inclination or as conduct. It naturally distinguishes between homosexual tendency, which in itself has nothing blameworthy to it, and homosexual practice which is always sinful – just as it distinguishes between the strong but not consented temptation to infidelity in a married person, and actual adultery on that person's part.

From the moral perspective then, homosexuality is a disorder; even though, as a simple tendency, it is not a sin. While a Christian juridical perspective naturally accepts that homosexuality is a disorder, canonical jurisprudence is concerned not with the moral aspect of the disorder, but with its effect on fundamental issues of justice and personal rights – including the capacity to exercise these rights.

34. As a possible canonical grounds of the nullity of marriage, homosexuality is treated almost exclusively within the ambit of c. 1095. This should not be permitted to lead to a neglect of its possible relevance under the terms of c. 1098. If, in order to bring about marital consent, a person deliberately conceals a deep-rooted homosexual tendency, a prima facie case is already present for a declaration of nullity due to "dolus", since such a condition certainly "of its very nature can seriously disturb the partnership of conjugal life" (cfr. c. 1098). If what had been deliberately concealed were not just a homosexual tendency, but previous homosexual activity, the case would be so much stronger. In cases of homosexuality, proper use of c. 1098, where appropriate, might also avoid questionable applications or stretched interpretations of the terms of c. 1095.

35. As we saw from the principles enunciated earlier, jurisprudence is agreed that a grave homosexual condition present at consent can provoke consensual incapacity under c. 1095, 3 . Care must be taken however lest judgments in this field be too absolute. Otherwise there is the danger of converting certain psychic anomalies which provoke consensual incapacity in *particular* circumstances (when the anomaly is grave; when the married obligations for which it incapacitates are constitutionally essential) into matrimonial impediments in *all* circumstances – which is clearly not the legislator's intent as expressed in c. 1095.

This caution applies to other conditions that are frequently dealt with under c. 1095. A formal sentence of consensual incapacity not only takes away the ecclesial right to marry of the person so judged, but deprives anyone wishing to marry him or her of the same right, at least as regards the marriage desired. No one can marry a person incapable of valid marriage consent. While the point may have less importance in regard to no. 2 of c. 1095 (a "grave defect of discretion" can at times be of a transitory nature), it calls for attentive consideration with respect to certain chronic or constitutional conditions that are at times invoked as grounds for the "incapacity of assuming" of no. 3 of the canon.

Jurisprudential interpretations in the sense that under c.1095, 3, grave kleptomania for instance, or chronic alcohol dependence, always incapacitates for valid marital consent, would imply that no one can validly

marry a professional thief or a chronic alcoholic. Even if one were fully aware of the crookery or alcoholism of another and nevertheless wanted to marry him or her, this would not be possible. Similarly, two alcoholics or two thieves who are in love with each other and wish to marry, would be impeded from doing so. The same would be true for two Obsessive-Compulsives, two with a "Dependent Personality Disorder" or an "Anti-Social Disorder". The practical consequence of overbroad or careless jurisprudence in these matters would be in effect to set up new canonical matrimonial impediments.

Declarations of nullity which correspond to truth and justice serve to protect and uphold ecclesial rights. Such rights however can be undermined if the principles underlying a declaration of nullity are not properly grounded in justice. It is only for very grave and solidly proven reasons that a person can be deprived of the natural and ecclesial right to marry (cf. c. 1058). The general principle, "laws which prescribe a penalty, or restrict the free exercise of rights, or contain an exception to the law, are to be interpreted strictly" (c. 18), can never be forgotten in the jurisprudential interpretation and application of the canonical dispositions which limit consensual capacity for marriage.

36. According to established jurisprudence, as we have noted, a mild or moderate homosexual condition does not justify a declaration of consensual incapacity. Several reasons bear out the prudence of this.

a) A "real" homosexual has an exclusive sexual attraction towards persons of the same sex and, at the same time, not simply a mere lack of such attraction but an actual *repugnance* regarding physical sexual relations with persons of the opposite sex. "When faced with a homosexual subject, a first question of major importance must always be made: that is, whether it is a case of a constitutional homosexual or of one that should be considered 'occasional'. To be justified in speaking of a real homosexual, i.e. of one who is constitutionally so, it is not enough that there be an attraction towards persons of the same sex. It is necessary that there also be a distaste for the other sex. Every homosexual who does not fulfil this last condition is probably an occasional homosexual... The true homosexual is an instinctual deviant in the proper sense of the term: everything occurs in him as if he were born of an element carrying sexual inversion in itself" (R. Zavalloni, *Elementi di psicopatologia educativa*, 1982, pp. 49-50). A declaration of incapacity for a valid marriage is certainly not justified in the case of an "occasional homosexual".

b) to have (or to have had, in the past) a *certain* homosexual

tendency is by no means infrequent. Whether persons with such a tendency are properly classified under the heading of "bisexual" (having a sexual orientation towards people of either sex) is a question that may be of interest to the psychiatrist, but it is not important to the ecclesiastical judge, since it is clear that such persons cannot be barred from exercising the right to marry. Their natural attraction to marriage remains and, if they marry, their usual motive is love for their partner. A recent study in a psychological review makes this point (also in relation to lesbians): "The great majority of bisexual or lesbian women reported that they got married because they were in love with their husbands and desired marriage... studies indicate that their marriages may be no more conflicted than heterosexual marriages" (Dr. Eli Coleman: "The Married Lesbian": *Marriage and Family Review*, vol. 14 (1989), pp. 121; 132).

c) the sentence of the appeal court in the case before us seems to look positively on the thesis that one can "speak of a homosexual tendency of antecedent gravity, and *for this very reason* incompatible with the assumption of matrimonial life" (II, 64). Here there is the danger of failing to distinguish not only between tendency and practice, but also between a bad tendency, which simply reflects fallen nature, and the curbing of that tendency which, along with showing moral strength, can also be inspired by love for one's partner.

There can be no grounds for holding that an immoral tendency, *if resisted*, can incapacitate a person for the undertaking or fulfillment of any essential marital obligation. Otherwise it would follow that someone very subject to sexual temptation is incapable of validly marrying, since he or she will go through married life with a constant urge to infidelity – although he is also determined to resist those temptations and has hitherto normally succeeded in doing so. This is surely not correct. Moreover, even if occasional falls were to occur during actual married life, it would seem impossible to conclude with certainty that this was due to incapacity, and not just to difficulty.

"A natural tendency can be irreversible without one's way of living necessarily following it. For either the supernatural struggle or the Christian 'sublimation' of the inclination can lead the person upward. After all, a genuine Christian life resists so many impulses of nature!" (c. Huot, Jan. 31, 1980: vol. 72, p. 85).

Therefore a tendency cannot be held to cause incapacity. We all have tendencies to act perversely. For the juridic proof of consensual incapacity, what has to be established is not the anomaly or pathology of having wrong tendencies, nor even that of yielding to them (which per se simply shows a *voluntary* giving way to a bad moral inclination), but the

anomaly of *not being capable of* resisting them.

Nor is this clear principle undermined by an expert opinion to the effect that the tendency in question is "constitutional" or "inherited". If the tendency is held in check, so that a person's *conduct* remains within the norm, the tendency cannot incapacitate. It is not a tendency which one manages to control, but conduct which one cannot control, that can sustain an allegation of incapacity under c. 1095, 3 .

d) The mutual exchange of the right to true conjugal acts is essential to the constitution of marriage. According to c. 1084, § 1, impotence or the inability to have sexual intercourse makes a valid marriage impossible (although the application of this rule to the marriage of an aged person is beset with evident difficulties). However, while the simple ability to perform the act is required, mainstream rotal jurisprudence has consistently refused to endorse any suggestion that the ability to give or derive sexual satisfaction through the act is an essential obligation under c. 1095. Thus, as regards frigidity in a woman (which is not accepted as a form of impotence: cfr. c. Pinto, July 15, 1977: vol. 69, p. 407), even tentative suggestions that it might be regarded as an incapacity for some essential matrimonial obligation under c. 1095, 3 have gathered no support (cfr. c. Serrano, July 28, 1981: vol. 73, p. 428), also no doubt because any such thesis could be held to show an element of sexual discrimination.

A homosexual tendency may render the conjugal act less satisfactory to one or both spouses, just as frigidity in the wife does. But (always allowing for the possible relevance of c. 1098) a "less than ideal" ability to perform the act offers no basis for a declaration of consensual incapacity under c. 1095.

Two older persons for whom the physical side of marriage – the actual conjugal act – is possibly of little or practically no interest, have the right to marry, even if this lack of interest derives from a rooted homosexual condition that was always present in one or other party.

e) If Church jurisprudence were to hold that any degree of homosexual inclination incapacitates for exercising the legitimate right to marry, this could be held discriminatory also in regard to the rights of homosexuals themselves. It would deprive them of the possibility of marrying someone whom they wish to marry and who, despite their condition, wishes to be united in marriage with them. From the supernatural point of view, they would be deprived of the special sacramental graces of marriage, which are such a powerful help to salvation and holiness.

A psychologist with broad experience in this field writes: "I have had contact with more than one homosexual whose marriage had been a great help in avoiding homosexual adventures and in [avoiding] abandoning himself to other neurotic inclinations. The situation of many married homosexuals is identical with that of other married neurotics. It is sensible to warn a homosexual as well as his future marriage partner of the difficulties they will almost certainly face if they decide to marry, but it must not be an iron rule to discourage such intended marriages" (Gerard J.M. van den Aardweg: *On the Origins and Treatment of Homosexuality*, Praeger, New York, 1986, p. 147).

We also note the observation of a first instance judge in a recent case which came to the Rota. He rejected the automatic assumption "that any person who is homosexual is unfit for a valid marriage... If this were the practical norm, then as a matter of policy and without respect to their human dignity and rights, such persons must never be permitted to marry to begin with; but such a policy would be against the person's natural right to seek out marriage as their call in life, not to mention that such a practice would be against the laws of the Church."

37. Some brief comment should be made regarding the DSM-III distinction between "ego-dystonic" and "ego-syntonic" homosexuality, uncritically accepted by the court expert and the judges in second instance in the case before us.

"Ego-dystonic" is used by DSM-III to indicate "a symptom or personality trait that is recognized by the individual as unacceptable and undesirable and is experienced as alien... A homosexual arousal pattern that is unacceptable to the individual would be ego-dystonic, whereas, if the individual were not distressed by the pattern and experienced it as acceptable, it would be ego-syntonic" (DSM-III, p. 359). According to this criterion, therefore, the homosexual who is "ego-syntonic" about his or her condition (i.e. who is not distressed by it but finds it acceptable), is not to be considered as suffering from any type of psychic liability (ibid., p. 282).

38. The idea that people can be in syntony – in positive emotional response – with any sort of tendency or conduct, is a logical consequence of the current philosophy of "self-definition", which opposes the notion of a given human nature, common to all, and therefore cannot accept that certain actions are "natural" and others "anti-natural". It holds that each person rather has the absolute right to define oneself, one's goals, and the parameters of personal conduct which one considers "acceptable"; all of which undoubtedly facilitates the ego-syntonic goal of "being at peace with oneself". In this view, conscience loses its character as a higher,

independent and critical voice of truth, and is reduced to an ego-syntonically regulated stamp of approval placed by the subject on whatever he or she wants to do.

The Church has always rejected this total moral subjectivism, this self-threatening current of thought in which freedom is exalted "to such an extent that it becomes an absolute, which would then be the source of values... in this way the inescapable claims of truth disappear, yielding their place to a criterion of sincerity, authenticity and 'being at peace with oneself'..." (*Veritatis Splendor*, no. 32).

39. Even if morality is left aside, two questions can be posed from the purely psychological point of view. First, is it possible that a person can feel "ego-syntonic" – that is, completely "at peace" and experiencing no personal distress at all – about *any action or form of conduct whatsoever* that he or she claims to consider acceptable: murder or rape, for instance? Secondly, if one allows that this is possible, can such subjective tranquillity about objectively inhuman conduct be taken as a sign of psychic normality, or ought it rather not be considered proof of grave mental pathology?

40. As in the case of the other "human sciences" (cfr. *Gaudium et Spes*, 5, 62; *Apostolicam Actuositatem*, 32; *Octogesima Adveniens*, nn. 38-40, etc.), the Church from the time of the 1941 Address of Pius XII to the Rota (AAS 33 423) has been cautiously positive in her approach to the rapid growth in scope and influence of modern psychiatry and psychology (*Christus Dominus*, 14; *Gravissimus Educat*. 1; *Optatam Totius*, 2-3, 20).

The legitimate analyses and suitable therapies proposed by these sciences can help diagnose and remedy the objective or subjective deficiencies of a psychic order which each person inevitably experiences in different stages or particular circumstances of life. In the past decades many local churches have felt the need for having psychological counsellors, in schools, seminaries, marriage or family centers, diocesan tribunals, etc. Persons already in the service of the diocese are now frequently selected for professional training in these fields.

The results have not in all cases been as positive as hoped for. The main concern which has emerged relates not so much to methods and therapies, as to the underlying *views of man* dominant in current psychology or psychiatry as well as in most faculties and schools which form people for the psychiatric or psychological professions: views that profoundly shape both theoretical understanding and practical approach regarding major anthropological questions such as fulfillment, freedom, identity, autonomy, dependence, commitment, sexuality, etc.

41. Particular dangers can arise in processes which examine pleas of the nullity of a marriage. From Pope John Paul II's addresses, it is clear that he wants ecclesiastical tribunals to be particularly attentive to them. In 1987, speaking to the Roman Rota, he warned of the "the very grave danger ... as regards decisions about the nullity of marriage" if the judge, unaware that "the anthropological view which underpins so many currents of thought in the field of modern psychological science is as a whole irreconcilable with the essential elements of Christian anthropology", were to give judicial weight to expertises based on false anthropological presuppositions (AAS 79 [1987] 1454-155).

Expertises used by tribunals must therefore reflect a Christian anthropology. In other words, the "values" which shape or condition their view of man (so providing the anthropological basis to their psychological or psychiatric inquiry into questions of psychic health ["normality"], illness, cure, etc.) must be in thorough harmony with the faith. Following the Pope's indication, a first concern of judges, at the moment of choosing an expert no less than at that of examining his opinion, is to grasp and evaluate the underlying anthropological principles and values which his approach and method reflect.

It is not possible to be in a position to discharge this special responsibility without a constant care for one's own Christian anthropological formation. This calls for deep familiarity with the growing richness of modern Christian anthropology which, with its age-old roots, casts an ever clearer light on all aspects of man's personal and social life. At the same time it confers a critical capacity in regard to modern psychological theories and therapeutical practices, so that one can distinguish what is in harmony with the view of human nature that the Church has always proposed, what is doubtfully compatible with this view, and what is clearly at variance with it.

42. As happens in practice, a Church tribunal may seek and receive an expert opinion submitted by a psychiatrist or psychologist of considerable prestige; or an expert may seek to strengthen his opinion with abundant reference to psychological or psychiatric studies, manuals or textbooks which are highly regarded by certain professionals (but perhaps not by others, as is exemplified by the case of DSM). Well and good; but if the opinion itself, or the works to which it refers in support, reflect a view of man out of harmony with that held by Christianity, the theses and analyses given may hinder rather than help the just solution of the case before the court. However well worked and documented an opinion, if it is inspired by a secularist view of man, it can be quite useless or thoroughly

misleading to an ecclesiastical court charged with the responsibility of judging capacity for matrimonial consent. If a judge lacks a due grasp of Christian anthropology, he is not likely to advert to the operative values underlying each expertise, or be able to fulfill his mission of deciding whether or not they are acceptable and applicable from a Christian point of view.

43. The insistence on the possession and application of Christian anthropological standards calls on court experts too, to check on their own working presuppositions. Not all experts whose services are regularly used by tribunals seem to be as aware as might be expected of the fact that while most of secular psychology considers certain dispositions or practices to be mutually incompatible or exclusive, Christian thought sees them as complementary and intrinsically designed for integration: freedom and commitment, for instance; or self-fulfillment and self-denial, "autonomy" and "relatedness", maturity and dependence. Secular psychologists quite regularly see "over-dependence" or "over-acceptance" as signs of an immature personality. A Catholic would be extremely cautious about applying such a criterion, above all when it comes to judging capacity for marriage which, in a Christian understanding, is a way of life that calls for a high degree of both mutual acceptance and mutual dependence.

The relationship between frequently invoked psychological concepts, such as "self-esteem" and "freedom from shame or guilt", or "self-doubt" and "self-actualization", would probably be interpreted quite differently according to whether one has a Christian or a secularist anthropological outlook. The same would hold no doubt for the nature and psychological evaluation of "self-image" or "self-assertion", or for the concepts of "validation" or of "healing". Similarly the parameters used to evaluate "sexual identity" would most probably not be identical (cfr. Malta sentence *coram* the undersigned of July 23, 1998, nos. 5-7).

44. One would expect court experts to show – and to communicate to judges – greater awareness of the differences and doubts abounding in the psychiatric and psychological professions. Judges would then be in a better position to weigh the certainty – whether of a scientific or a probatory nature – that is due to specialized terminology or particular manuals used, or to concrete opinions given in an expertise. It must be said nevertheless that to find a court expert express a "caveat" in this sense, such as that regarding DSM in the decision c. Ragni of May 19, 1992 (n. 18 above), is a rare occurrence.

45. No criticism of the invaluable role played by so many psychiatrists

and psychologists is implied in suggesting that when some among them claim that their professions operate from a strictly *scientific* and "value-free" basis, the onus lies on them to substantiate the claim; for, as we have shown, it is contested by many distinguished figures from within the professions themselves, who even hold that it is not possible for psychiatry or psychology to be "value-free" in fact. No ecclesiastical judge can afford to be unaware of or ignore the very discordant views on this which exist within these fields. Recalling what the Harvard Professor, Dr. Alan A. Stone, said in 1980 in relation to psychiatry (no. 25 above), we quote from a recent article in a major psychological review which holds that there is "an increased awareness concerning the role of values in psychology", and a consequent reaction among psychologists against "the legacy of value-free doctrines" (Isaac Prilleltensky: "Values, Assumptions, and Practices": *American Psychologist*, vol. 52 [1997], p. 517).

46. The importance of these questions to church tribunals should be evident, nor is there any need to posit the unlikely hypothesis that some judge might unconsciously consider that jurisprudence should be subordinate to the "scientific certainties" of psychiatry or psychology. From the canonical viewpoint, the simple fact is that these ongoing debates touch directly on anthropological issues central to cases heard under c. 1095, for they concern the fundamental parameters of human development and personal maturing.

47. One would be greatly hampered in serving both the Church and humanity if one were unaware of the state of recurrent uncertainty and problematic change that characterizes so much of modern secular psychology and reveals its limited human resources and its narrowed frame of reference. The following passage from another recent article could be emblematic of how the proper identification of a real problem can be followed by an inadequate [dialectical] analysis, without a substantial or time-tested solution being offered. "Traditionally, the indigenous psychologies of Western industrialized cultures have stressed the importance of the development of individuality, autonomy, independence, achievement motivation, and identity as essential components of psychological maturity. Social critics suggest that these values have also led to a long-standing and intensifying crisis of alienation in the Western world... Within psychology, the tradition of emphasizing the importance of the development of the self and of identity over the development of social relations has increasingly been challenged by theorists interested in attachment, psychoanalytic object relations, feminism, and non-Western psychologies" (S. Guisinger and S. J. Blatt: "Individuality and Relatedness:

Evolution of a Fundamental Dialectic": *American Psychologist*, vol. 49 [1994], p. 104).

It is perhaps even more for what it omits, than for what it says, that this passage seemed worth quoting. A psychology properly rooted in the Christian faith has very much indeed to contribute to such questions being debated among secular psychologists, precisely because it has always placed the "development of self" and the "development of social [i.e. interpersonal] relations" side by side, and as necessarily interdependent, being in fact expressions of the same virtue of charity which harmonizes love for self with love for others. As the *Cathechism of the Catholic Church* says: "Through the exchange with others, mutual service and dialogue with his brethren, man develops his potential; he thus responds to his vocation" (no. 1879).

48 . Perspectives begin to broaden indefinitely at this stage, as one's realization grows of how deeply contemporary psychiatry and psychology are in need of the view of man offered by Christian anthropology. To pursue that aspect further, however, is not of our present competence.

References

1. *R.R.Dec.* refers to the officially published volumes of rotal decisions. "c" (or "*coram*") indicates the Presiding Judge in the particular case cited.